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Annual Review 1987

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Office of the Chief Medical Examiner

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Annual Review 1987

Office of the Chief Medical Examiner

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Introduction

The Office of the Chief Medical Examiner of the Province of Alberta is responsible by statute* for investigation and certification of all deaths by violence, as well as unexpected, unexplained and some unattended deaths. Certain hospital and institutional cases, notably those of persons dying within 10 days of surgery or anesthesia, are included. Deaths of persons held involuntarily in any institution are also investigated. The area of jurisdiction is the Province of Alberta, with a population of approximately 2.3 million.

The Medical Examiner system, under the direction of the Chief Medical Examiner, is managed from two regional offices, one located in Calgary and the other in Edmonton. The Chief Medical Examiner is based in Calgary. Both regional offices are under the direction of a Deputy Chief Medical Examiner. The Edmonton office administers the northern part of the province, and the Calgary office administers the geographical area south of a horizontal line between Jasper and Provost, through Hobbema. Each office has a permanent staff of medical investigators, forensic autopsy technicians and medico-legal records technicians. Additional staff members include administrators, photographers/radiographers, a research officer and assistant, and secretaries. There are complete toxicology and histopathology laboratories in both Calgary and Edmonton. The toxicology laboratories are directed by Ph.D. biochemists who direct technologists in their work.

A medical investigator and medical examiner are on duty evenings and weekends for investigations and consultations. Autopsies and examinations are performed daily.

Approximately 150 medical examiners and 25 pathologists are on a part-time, fee-for-services basis throughout the province. In the two central offices, approximately 50 per cent of the medical examiner cases were investigated and certified by the full-time medical examiner's staff. The remainder of the cases were examined and certified by part-time medical examiners who are assisted by pathologists, city police, and RCMP in other parts of the province. Their continuing support and willingness to perform this valuable community service has made it possible to maintain a high-quality provincial Medical Examiner system.

The Office of the Chief Medical Examiner in Alberta started the medical investigator programme in Canada, and was the first such system anywhere to recruit persons with exclusively medical training to fill the role as investigators. The idea has now received support in the United States. The Office of the Chief Medical Examiner in Alberta was the first medico-legal jurisdiction in Canada to be inspected and accredited by the National Association of Medical Examiners, an American based organization whose standards for accreditation of medical examiner/coroner systems and facilities are unique.

The Office is associated with the universities of Calgary and Alberta and provides training to students, trainees and professionals in various health-related disciplines, law students, and police officers. The Office has the only programme in Canada approved by the American Board of Pathology for training towards the Board's examination in forensic pathology.

The Office of the Chief Medical Examiner in Alberta began a tissue donation programme in 1984. Next-of-kin were contacted very shortly after the death and asked to consent to donating the corneae of the deceased. This year 37 pairs of eyes were made available, representing a positive response from 66 per cent of those families approached. To date 206 pairs of eyes have been donated through this programme. In 1987, a total of 4,451 deaths were reported to the medical examiner. This accounts for approximately one out of three deaths in Alberta during that period. The report developed by the medical examiner in each case contains information on the cause, manner and circumstances surrounding the death.

*The Fatality Inquiries Act and the Vital Statistics Act.

Caseload Statistics

Total Cases

Certified Cases

Manner of Death	Total Cases	Aggregate Rate per 100,000 population
Natural	1,879	78.9
Homicide	69	2.9
Suicide	392	16.5
Accidental	858	36.0
Unclassified	175	7.3
Undetermined	81	3.4
Other Cases*	997	—
TOTAL	4,451	185.6

*Other Cases: cases which are reported but do not require a full investigation. (See Refereed Cases.)

Regional Distribution of Cases

	Calgary	South Rural	Edmonton	North Rural	Total
Natural	457	409	636	377	1,879
Homicide	21	13	25	10	69
Suicide	88	63	118	123	392
Accidental	125	237	203	293	858
Unclassified	42	20	84	29	175
Undetermined	27	17	23	14	81
TOTAL	760	759	1,089	846	3,454

Caseload Review 1978 – 1987

	Calgary	South Rural	Edmonton	North Rural	Total
1978	783	796	902	911	3,392
1979	920	876	1,084	975	3,855
1980	1,011	957	1,142	983	4,093
1981	944	934	1,223	917	4,018
1982	973	838	1,325	884	4,020
1983	965	826	1,295	849	3,935
1984	748	875	1,286	908	3,817
1985	633	874	1,244	849	3,600
1986	766	795	1,217	922	3,700
1987	760	759	1,089	846	3,454

Refereed Case Review *

	1981	1982	1983	1984	1985	1986	1987
Calgary	323	295	304	463	601	465	389
South Rural	70	45	104	158	91	104	81
Edmonton	124	98	225	201	303	312	418
North Rural	41	45	58	61	81	94	109
TOTAL	558	483	691	883	1,076	975	997

* "Refereed" cases are deaths reported to the Medical Examiner according to Section 15 of the Vital Statistics Act, and deferred to the attending physician on the basis that the death was natural, that he is able to certify the medical cause of death with reasonable accuracy and that he has received the consent of the medical examiner.

Types of Death Investigated and Certified

Homicides

	Male	Female	Total
Calgary	12	9	21
South Rural	6	7	13
Edmonton	17	8	25
North Rural	6	4	10
TOTAL	41	28	69

Alberta rate per 100,000 population	2.9
Canadian rate per 100,000 population	1.7

Method

Fight/brawl	16
Hanging/strangulation	6
Firearms	19
Stabbing/incised wound	18
Child abuse	5
Motor vehicle	1
Fire, burns	3
Premature labour	1
TOTAL	69

Suicides

Age Group	Male	Female	Total	Rate/100,000
10 – 14	3	0	3	1.7
15 – 19	30	5	35	19.1
20 – 24	38	1	39	18.1
25 – 29	47	10	57	22.9
30 – 34	44	4	48	20.5
35 – 39	23	11	34	17.9
40 – 44	25	6	31	20.5
45 – 49	27	7	34	29.4
50 – 54	20	3	23	22.4
55 – 59	26	5	31	32.4
60 – 64	14	1	15	18.3
65 – 69	18	5	23	33.8
Over 70	16	3	19	14.6
TOTAL	331	61	392	16.5

Month of Death

	Calgary	South Rural	Edmonton	North Rural	Total
January	7	2	10	15	34
February	9	9	7	6	31
March	6	3	13	11	33
April	8	6	12	19	45
May	5	6	15	11	37
June	9	4	12	12	37
July	7	7	5	9	28
August	7	7	7	5	26
September	6	6	8	8	28
October	10	7	7	9	33
November	6	3	9	11	29
December	8	3	13	7	31
TOTAL	88	63	118	123	392

Suicides 1975 – 1987

	1975	1980	1985	1986	1987
Calgary	78	103	105	84	88
South Rural	69	91	88	89	63
Edmonton	68	99	102	137	118
North Rural	72	107	100	121	123

Suicide Rates Per 100,000 Population

Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000
1960	1,291.1	115	8.9
1965	1,450.0	162	11.2
1970	1,595.0	204	12.8
1975	1,811.8	287	15.8
1980	2,205.1	400	18.1
1985	2,348.8	395	16.9
1986	2,389.5	431	18.0
1987	2,380.4	392	16.5

Method

	Male	Female	Total	Percentage
Drug overdose/poison	43	33	76	19
Carbon monoxide	77	16	93	24
Hanging/strangulation	64	4	68	17
Submersion	3	1	4	1
Firearms	124	4	128	33
Incised wounds	2	1	3	1
Jumping	11	1	12	3
Other	7	1	8	2
TOTAL	331	61	392	100

National Suicide Rates* Per 100,000 Population 1975 – 1987

	1975	1980	1985	1986	1987
National Rate	12.4	14.0	12.9	14.5	14.0
Newfoundland	3.5	3.4	4.0	4.0	4.9
Prince Edward Island	11.9	11.4	3.9	11.1	8.6
Nova Scotia	10.4	11.5	12.0	10.8	12.6
New Brunswick	8.0	11.6	12.0	13.5	10.5
Quebec	9.3	14.8	17.1	17.6	17.9
Ontario	13.5	13.1	11.4	12.4	11.5
Manitoba	13.1	11.8	11.9	14.4	15.8
Saskatchewan	14.9	15.9	13.0	13.7	13.0
Alberta	15.8	18.1	16.9	17.9	16.1
British Columbia	16.9	14.8	10.4	14.7	14.1
Yukon**	1.9	5.0	3.5	4.3	2.8
Northwest Territories**	1.7	2.0	2.5	2.9	2.9

*Source: Statistics Canada

**Rates based on 10,000 population

Accidental Deaths

Motor Vehicle Accidents

	Calgary	South Rural	Edmonton	North Rural	Total
Driver	27	97	29	104	257
Passenger	10	53	18	66	147
Unknown occupant	0	0	0	1	1
Subtotal	37	150	47	171	405
Pedestrian Struck by Motor Vehicle	16	16	21	12	65
Motorcycle Accidents	14	8	7	8	37
Train Collisions					
Driver of motor vehicle	0	1	0	2	3
Passenger in motor vehicle	0	0	0	0	0
Pedestrian	3	4	1	2	10
Subtotal	3	5	1	4	13
Bicycle Accidents	0	2	4	4	10
Motor Vehicle Collapsed on Victim	1	2	1	4	8
TOTAL MOTOR VEHICLE ACCIDENTS	71	183	81	203	538

Industrial Accidents

Asphyxia	2
Crushed by equipment	5
Drilling rig collapse	1
Drowning	2
Explosion	2
Fall	5
Mining	2
Struck by object	7
Struck by train	1
Struck by tree	3
TOTAL INDUSTRIAL ACCIDENTS	30

Farm Accidents

Equipment roll over	3
Crushed by machinery	8
Caught in equipment	6
Clothing entangled in hopper	1
Electrocution	1
Fire	1
Lightning	1
Struck by chain	1
TOTAL FARM ACCIDENTS	22

Other Accidents

Air crash	8
All-terrain vehicle	5
Asphyxia	12
Aspiration	16
Avalanche	3
Burns	2
Carbon monoxide	11
Crushed by object	3
Dirtbike	1
Drowning	38
Drug overdose	2
Electrocution	2
Explosion of beer keg	1
Fall	73
Fall from horse	3
Firearm	5
Fire	30
Hang glider	1
Hypothermia	7
Inhalation of aerosol	1
Late effects of trauma	3
Lightning	1
Shaken	1
Snowmobile	2
Struck by boat	1
Therapeutic misadventure	9
Tornado	27
TOTAL OTHER ACCIDENTS	268

TOTAL ACCIDENTAL DEATHS **858**

Unclassified Deaths*

Causes of Death	Calgary	South Rural	Edmonton	North Rural	Total
Chronic and/or acute alcoholism and sequelae	22	11	39	16	88
Drug overdose	11	0	26	5	42
Alcohol and drug overdose	9	2	14	4	29
Hypothermia due to intoxication	0	4	0	0	4
Methyl alcohol	0	3	4	2	9
Solvents	0	0	1	1	2
Fire related to intoxication	0	0	0	1	1
TOTAL	42	20	84	29	175

* Evidence of alcoholism or drug misuse is a direct part of the primary medical cause of death.

Undetermined Deaths*

Causes of Death	Calgary	South Rural	Edmonton	North Rural	Total
Unable to determine exact cause of death	13	9	5	3	30
Drugs and alcohol overdose	2	0	1	0	3
Drug overdose	7	1	2	1	11
Carbon monoxide	2	0	3	0	5
Drowning	1	3	2	0	6
Burns, fire	0	1	0	1	1
Asphyxia	0	0	0	1	1
Motor vehicle accident	0	2	1	4	7
Hypothermia	0	1	0	0	1
Methyl alcohol	2	0	0	0	2
Blunt trauma	0	0	8	2	10
Hanging	0	0	1	0	1
Gunshot wound	0	0	0	1	1
Strychnine poisoning	0	0	0	1	1
TOTAL	27	17	23	14	81

* Undetermined whether accidental, self-inflicted, or homicide.

Sudden Infant Death Syndrome

Age Group	Calgary	South Rural	Edmonton	North Rural	Total
Less than 1 month	2	0	1	2	5
1 – 3 months	9	9	17	10	45
4 – 6 months	6	1	1	1	9
7 months and older	0	1	3	0	4
TOTAL	17	11	22	13	63

Sudden Infant Death Syndrome is the leading cause of death among infants from one week to one year of age. In Alberta, S.I.D.S. accounted for 63 infant deaths in 1987. The overall incidence of S.I.D.S. has been reported as 1.8 cases per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Alberta is during the first three months.

S.I.D.S. Statistics for Selected Cities

	1980	1981	1982	1983	1984	1985	1986	1987
Calgary	14	22	24	15	12	11	19	17
Edmonton	17	25	26	26	22	27	28	22
Lethbridge	3	2	4	0	1	1	5	2
Fort McMurray	0	0	1	0	3	1	2	0
Red Deer	4	1	1	1	0	1	2	0
St. Albert	0	0	1	0	1	0	0	0
Medicine Hat	2	2	1	2	2	1	1	1
Leduc	0	0	1	0	1	0	1	0
Grande Prairie	0	0	1	0	2	0	3	0
Camrose	0	0	1	0	0	0	1	0

Public Inquiries

Public Inquiries Summary

Manner of Death	Judicial Recommendations for the Prevention of Similar Deaths: Given	Not Given	
Natural	0	1	
Homicidal	0	0	
Suicidal	2	3	
Accidental	8	9	
Unclassified	1	2	
Undetermined	1	3	
TOTAL	12	18	= 30

Types of Public Inquiries

Hospital/Institutional Related	
Suicidal	2
Undetermined	2
Accidental	
Choking	1
Medical misadventure	1
Toxic drug interaction	1
TOTAL	7
Occupational Related	
Explosion	1
Drowning	1
TOTAL	2
Police/Incarceration Related	
Suicide	3
Undetermined	1
Unclassified	3
Accidental	
Fall	2
Motor vehicle chase	5
TOTAL	14
Other	
Natural	1
Undetermined	1
Accidental	
Drowning	2
Explosion	2
Other	1
TOTAL	7
TOTAL PUBLIC INQUIRIES	**30**

1987 Public Inquiry Summaries

Case History 1

Suicide. The decedent was found hanging in a cell at the Edmonton Remand Centre. Concerns that the decedent was a suicidal risk were not immediately made known to custodial personnel upon his arrival at the remand centre.

Recommendations:

1. All documentation which would assist the 'intake of personnel' at any institution, when a prisoner is transferred from one establishment to another, should be with the prisoner being transferred and should not be the subject of a follow-up dossier.
2. Full reasons for 'bail refusals' accompany the prisoner back to the custodial authority at all times.

Replies:

ROYAL CANADIAN MOUNTED POLICE

The RCMP have a policy in place designed to alert correctional staff, involved in handling suicidal or dangerous prisoners, to these concerns.

We are endeavoring to ensure our detachment members adhere to our policy, and we will continue to monitor same.

ALBERTA SOLICITOR GENERAL

The recommendations have been brought to the attention of the Director of Law Enforcement. He has informed all law enforcement agencies within the province, involved with prisoner handling and escort, of the necessity of timely reporting of information concerning the welfare of prisoners.

EDMONTON REMAND CENTRE

All recommendations as applicable to police agencies and courts are acceptable to the Remand Centre. In addition, our psychologist continues to interview all inmates charged with murder.

Case History 2

Accidental. The decedent's vehicle went through a stop sign and was struck by another vehicle. There were no signs warning of the approaching stop. Road conditions were poor at the time.

Recommendations:

1. Roads intersecting major highways should have signs warning of approaching stop signs.
2. All vehicles should have their lights on at all times while moving, particularly on two-lane (two-way) highways and even on four-lane highways.

Replies:

ALBERTA TRANSPORTATION AND UTILITIES

1. Policies are in place for erection of warning signs on highways under the department's administration. The department attempts to provide guidance and advice to municipalities but does not have the authority to require them to erect traffic control signs.
2. The department supports driving with lights on. A program encouraging the use of regular or special daytime driving lights is getting underway. The federal government has announced that in the fall of 1989 all new vehicles will require automatic daytime driving lights.

Case History 3

Suicide. The decedent was found hanging from a tree near an abandoned residence on the Samson Reserve. She was subject to permanent guardianship orders under the provisions of the Child Welfare Act. She had a history of running away from foster homes, and child welfare workers could not maintain contact with her.

Recommendations:

When the conduct of the subject of a temporary or permanent guardianship order is such as to display a course of conduct that does not comply with minimum requirements as from time to time established, then subject to the qualification hereinafter set out, either legislation or at least departmental policy should require a child welfare worker to make application for a Secure Treatment Order.

A minimum standard of conduct established by legislation or by departmental regulation would include, among other things:

(a) residence in an approved foster home, receiving home, group home or approved commercial boarding home; and

(b) regular attendance at school until at least the age of 16 years.

The qualification mentioned above would relax the requirement of an application for Secure Treatment Order, where the approval of the Children's Guardian is obtained in

respect of a case plan that is at variance with such minimum standards.

Replies:

CHILDREN'S GUARDIAN

I have initiated a review of this report and hope to reply shortly.

ALBERTA SOCIAL SERVICES

1. Secure treatment is the most drastic and restrictive measure available under the Child Welfare Act, and such restrictive interventions should be reserved for the most critical of cases.
2. Regular attendance at school and failure to remain in a placement do not amount to eligibility for secure treatment.
3. Replacement of the current criteria for admission to secure treatment would require a major funding reallocation to the detriment of less restrictive measures that are equally and perhaps more effective than secure treatment services.
4. To meet the needs of children, we propose to concentrate on program and procedural initiatives and, if necessary, legislative solutions.

Case History 4

Suicide. The decedent was behaving as if intoxicated with alcohol while at the Slave Lake Hospital. She was offered but refused treatment, and instead accepted a ride home. She was found dead the following morning. There were numerous empty medication bottles at the scene. Death was due to an overdose of codeine.

Recommendations:

1. All persons who are in the position of coming into first contact with distressed individuals should receive the benefit of any training or education which would assist them in recognizing that a particular person is in a high-risk group for the infliction of self-injury.
2. The training should include methods of dealing with such people in a way that would encourage them to confide in the staff and thus enable a diagnosis of the problem to be made.
3. Finally, the training should teach the staff how to persuade the person to accept the assistance and, where appropriate, treatment available.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

Alberta Hospitals and Medical Care has requested that the regional team in the institutional operations branch of the department discuss the steps taken by the hospital to provide appropriate training for their staff. A visit is planned at which time the hospital will also be encouraged to support training for staff to ensure that appropriate care is provided for distressed individuals presenting for treatment.

ALBERTA ASSOCIATION OF REGISTERED NURSES

We support the participation of staff of the Slave Lake Hospital in courses that address the matter of high-risk populations in relation to suicides.

We suggest also that it be the policy of the hospital that a Registered Nurse be involved in assessment of any person who appears at the hospital in an unusual state.

SLAVE LAKE GENERAL HOSPITAL

The following actions have been implemented over the past year:

1. Slave Lake Hospital was instrumental in initiating a health related interagency group in November 1986 which meets monthly. The group consists of representatives of AADAC, Mental Health Services, Social Services, Public Health & Home Care, Native Friendship Center Counselling Services, and medical, nursing and administrative staff. This group discusses areas of common concern, becomes aware of other services and does case reviews. This has resulted in improved referrals to other agencies and an improved working relationship between the agencies.
2. The hospital has a representative on the board of the recently organized Crisis Line Society.
3. An inservice program conducted by Mental Health Services was held in December 1987 dealing with suicide intervention. Further inservice programs will be planned. The issues addressed in the judges recommendations were/will be dealt with by inservice programs.

UNIVERSITY OF CALGARY, FACULTY OF SOCIAL WELFARE

1. The faculty supports the finding that persons who are in the position of coming into first contact with distressed individuals should receive the benefits of training or education which would assist in recognizing that a person is in a high-risk group for infliction of self-injury.

2. We have acted upon the recommendations through research and development activities of one of our faculty members who, in conjunction with other disciplines, implemented Alberta's suicide prevention training programs for "first contact" caregivers. As well, our faculty offers students a senior elective course in crisis intervention.

3. Alberta Suicide Prevention Training Program (S.P.T.P.) has a certified trainer residing in Slave Lake. There have been several S.P.T.P. workshops in the Slave Lake area since 1985.

ALBERTA SOCIAL SERVICES

Child protection staff do receive training, and policies are in place as to what precautions must be taken when dealing with behaviours related to self-inflicted injury or suicide indicators.

ROYAL CANADIAN MOUNTED POLICE

"K" Division Training and Development Branch advise that they are not aware of training methods that can specifically identify people that may be subject to suicide. It is not the intention of the RCMP in Alberta to embark on a training program of this nature, as the cost is prohibitive and the benefits doubtful.

NATIVE COUNSELLING SERVICES OF ALBERTA

Native Counselling Services was involved in suicide prevention and training, but due to funding cutbacks, had to move it down in priority. We do, however, have staff volunteering and working in the system when needed.

PROVINCIAL SUICIDOLOGIST

The Province of Alberta provides funding to the Canadian Mental Health Association, Alberta Division, for a two-day suicide prevention program workshop dealing with attitudes towards and knowledge about suicide, which presents a model for assessing risk and crisis intervention, and facilitates identification of additional resources available to a suicidal person. Over 70 workshops have been delivered over the past year. Hospital staff are strongly urged to participate in such a training program.

ALBERTA INDIAN HEALTH CARE COMMISSION

No reply to date.

Case History 5

Accidental. The motor vehicle operated by the decedent on Highway #2 collided with a horse. There was no indication of skid marks or that the deceased had any time to react. The driving conditions were good. There was no evidence of abnormal driving.

Recommendations:

1. That texas gates or cattle guards be installed at every intersecting road and private entrance along Highway #2, with adequate contiguous fencing up to the texas gate.

2. That prominent, easily identifiable and sufficient signage be installed along Highway #2 to warn motorists of the presence of domestic stock.

3. That night-time speed along Highway #2 be reduced to 80 kilometers per hour.

4. That steps be taken to ensure that all domestic animals on the Blood and Peigan Reserves be adequately identified as to ownership by branding or other suitable marking so that liability can be fixed in the event of an accident.

5. That steps be taken in order to finalize responsibility as to upkeep of all fencing as indicated in the attached letter and transcript.

6. That a review of the open range policy in effect on both the Blood and Peigan Reserves be undertaken by various levels of government.

7. That a review be taken as to the adequacy of four-strand fencing.

8. That a copy of this report be forwarded to the addresses indicated in the attached letter.

9. That adequate patrolling of all fencing be initiated and conducted on a continuous basis.

Replies:

ALBERTA SOLICITOR GENERAL

Since this would appear to be a driver related incident, the department cannot recommend any changes from the Motor Vehicles Division's perspective.

ALBERTA TRANSPORTATION AND UTILITIES

An interdepartmental committee has been established to review the recommendations. This committee consists of representatives from various branches of this department and also the Departments of the Attorney General, Federal and Intergovernmental Affairs, Municipal Affairs and Forestry, Lands and Wildlife. Discussions with the Peigan and Blood Indian Bands and the federal government are ongoing. The committee's response is as follows:

1. The situation with regard to fencing and cattle guards along Highway #2 through the Blood Reserve will be investigated to determine the action required to provide a reasonable standard of protection from stray domestic animals. The department will negotiate with the Indian Band regarding fencing requirements, the placement of cattle guards and the maintenance of these facilities. The department will also proceed forthwith with the installation of facilities that are reasonably anticipated to lessen the hazards to highway users, while continuing to recognize the responsibility of livestock owners to prevent the straying of their animals.

2. Oversize livestock warning signs will be erected on Highway #2, at two locations northbound and southbound.

3. A reduced speed limit would be inconsistent with the highway construction standard and other provincial speed limits. The result of reducing the speed limit would be widespread disregard of the posted speed limit. Furthermore, the speed differential at night would not significantly improve the avoidance factor. The decision of the committee is not to reduce the speed limit at this time.

4. With respect to recommendations 4, 5, 6, 7 and 9, the committee will develop a listing of factors requiring consideration in relation to branding and open range policy. Matters related to fencing standards and maintenance will be further investigated. These items will require extensive discussion with the federal government, in an attempt to develop comprehensive provincial guidelines for all legal and physical aspects of highway protection through Indian reserves. It is not the department's intention to shoulder all liability for stray animals. It is clear that the owners of the animals have the principal legal responsibility to contain their animals.

ALBERTA ATTORNEY GENERAL

The subject matter of the recommendations are not within the mandate of this department.

INDIAN AFFAIRS AND NORTHERN AFFAIRS CANADA

The question raised by this incident may best be addressed by the co-operative efforts of the Province and the Blood and Peigan Bands.

ALBERTA FORESTRY, LANDS AND WILDLIFE

There is no public land owned by the Province of Alberta immediately adjacent to Highway #2, south of Fort Macleod. Therefore, the department has no jurisdiction to act on the recommendations with regard to fencing and range management.

BLOOD TRIBE ADMINISTRATION

The Blood Tribe is making arrangements to meet with the federal and provincial officials to discuss this matter.

ALBERTA MUNICIPAL AFFAIRS

Recommendations resulting from the inquiry are not directly applicable to Alberta Municipal Affairs.

Case History 6

Undetermined. The decedent had attempted suicide by ingesting phenobarbital. He was transported to hospital, sedated and observed overnight. He was then transferred to Alberta Hospital, Edmonton where further visual checks were ordered every 15 minutes during the night. He was found not breathing at seven o'clock the following morning and could not be resuscitated. Autopsy and toxicology reports offered no explanation for the cause of death.

Recommendations:

It is recommended that when a patient with a history of attempted suicide and possible drug overdose is admitted, the regular periodic checking of the patient should consist of more than just visual checks and that the patient's vital functions should be checked on a regular basis during at least the shift period immediately following admission.

Replies:

ALBERTA HOSPITAL, EDMONTON

The hospital has reviewed the recommendations, and a memo was drafted with concurring changes to be incorporated in the procedure manual.

ALBERTA HOSPITALS AND MEDICAL CARE

Recommendations duly noted. Alberta Hospital, Edmonton officials are developing policy to implement these recommendations.

ALBERTA COLLEGE OF PHYSICIANS & SURGEONS

No reply to date.

Case History 7

Accidental. The decedents were descending Mount Baker during an instructional expedition when they suddenly could no longer control their descent and slid down the mountain, dislodging the wet snow. Death was due to asphyxia.

Recommendations:

1. It is recommended that a licensing system be set up and rigorously enforced as to the qualifications of mountain guides, both within federal and provincial jurisdictions and as to organizations who are paid for providing guiding services. These regulations should provide for the ratio of guides in relation to the number of climbers taking into consideration the experience of the guide and climbers. As well, the regulations should provide for a rescue system in the sense that where a climbing group is caught, for whatever reason, and cannot descend without considerable danger, then a mechanism should be available to extract those climbers from the dangerous position.
2. Guides should carry radio transmitters on their expeditions.
3. Taxpayers should not have to pay for the rescue of mountain climbers, especially in the case where an organization is receiving a fee to provide the service of guiding.
4. All guiding businesses should be compelled to provide a workable support system whereby the mountain rescue services of the parks systems covered by federal or provincial jurisdiction can be immediately contacted for assistance.

Replies:

ASSOCIATION OF CANADIAN MOUNTAIN GUIDES

1. A licensing system is in place. ACMG certification is used as a prerequisite for issuing licences, but there is no legislation to back them up. The ACMG membership has agreed to support an even firmer enforcement of our guidelines.
2. Establishing a guide-to-client ratio is impractical, due to a variety of possible situations — guide, terrain, client's ability.
3. Until there is a series of repeaters, which are available to the public, it is impossible to establish a communication link over the distance involved. When and if the satellite communication system becomes workable and affordable, we will recommend radios as standard equipment.

YAMNUSKA MOUNTAIN SCHOOL

1. The main cause of accident was judgement error in choice of anchor; other factors are immaterial to the situation.
2. We support a system of licensing.
3. To regulate the industry by mandating rigid guide/client ratios will hamper flexibility in a guide's ability to conduct business, predetermine the kind of experience a client can buy, and do little to enhance their safety or quality of experience.
4. We disagree with guides carrying radios to prevent accidents. In some situations, carrying a radio could have a detrimental effect.
5. We agree with the taxpayer not having to pay for costs of rescues; however, rescue fees would be passed on to consumers, resulting in more climbers going into the mountains with less training.
6. Yamnuska Mountain School has recommended a procedural change to its staff: whenever practical, use multi-point anchors for belaying or lowering in snow or ice terrain.

PARKS CANADA

1. Existing legislation is under review to update guide categories and establish appropriate standards for each category of guide. Means of enforcement, in addition to existing legislation with regard to license removal for infractions, are being reviewed.
2. New regulations will not provide for a rescue system nor stipulate guide-client ratios. We will review training criteria for client-guide ratio standards of any sanctioning body we recognize (e.g., Association of Canadian Mountain Guides).
3. Expansion of a radio support system would cost in excess of five million dollars using current technology. The costs are currently prohibitive.
4. Parks Canada provides for visitor activities which are dependent on natural resources and require a minimum of man-made facilities. This policy recognizes the responsibility of the agency to inform and educate visitors of the risks and responsibilities of the sport of mountaineering and the responsibility of the visitor to exhibit a degree of self-reliance and responsibility for their own safety commensurate with the degree of difficulty of activities they undertake.

ALBERTA RECREATION AND PARKS

1. Alberta Recreation and Parks currently has adopted a licensing system that requires certification by the Association of Canadian Mountain Guides. The department continues to work directly with ACMG to update and modify the certification standards and training/testing programs utilized in this licensing system.

2. We agree with the recommendation that standards should be enforced with respect to mountain guides operating in both provincial and federal jurisdictions.

ALBERTA FORESTRY, LANDS AND WILDLIFE

Due to the extensive nature of public lands and variety of activities that occur, implementation of a licensing and issue system would be difficult and costly to administer. The department will, however, continue to monitor the use of public lands and resources and to co-operate with emergency support services, RCMP and the military.

Case History 8

Accidental. The decedent was found unconscious in a public swimming pool by a lifeguard. He could not be resuscitated.

Recommendations:

1. The duties of at least one lifeguard on duty should encompass ensuring that young unaccompanied non-swimmers do not reach the main swimming pool from the wading pool.
2. Access into swimming pool facilities should be effectively controlled.
3. It is not the function of a fatality inquiry to determine legal responsibility, nor the extent to which various factors may have contributed to the fatality. It is clear that it cannot hurt to remind young (and experienced) lifeguards again: lifeguarding is a serious business *all the time*. The executive director of the Royal Life Saving Society, who sat in on the major portion of the evidence heard by the inquiry and who teaches, amongst others, courses to instructors of his society, recommended:
   a) in relation to a lifeguard's assessment whether intervention is required, it's better to get wet than jumping in too late;
   b) lifeguards need to watch especially for "gutter grabbers" and for the expressions on the faces of people in the water, not just their numbers; and
   c) that there be *frequent* and regular inservice training.
4. That consideration be given to adding the National Lifeguard Service Award as a requirement for qualification as a lifeguard; this on the proposition that the better the training, the better chance there is to prevent loss of life.
5. Consideration should be given to segregation by fencing or otherwise of younger non-swimmers to keep them away from deep water.

Concern was expressed over irregular patches in pools such as may be caused by paint peeling.

Replies:

ROYAL LIFE SAVING SOCIETY

The Royal Life Saving Society of Canada and the Northwest Territories branch does not have regulatory privileges for establishing individual staffing guidelines; however, we highly recommend that the National Lifeguard Service be used as a vital training award.

CANADIAN RED CROSS

1. Access between pools should be limited by physical barrier. Where a gate is present, it should be secured so that it may only be opened by an adult.
2. No child under the age of six should be permitted to use wading pools, unless direct supervision is provided by an adult.
3. Children must be of school age and be able to stand in the shallow end unaided prior to their being allowed entry to a public swimming pool. Others must be accompanied by an adult whose role it is to supervise the child.
4. One of the rules posted at pools should pertain to the role of the adult in supervising their child. Many parents simply assume it is no longer their responsibility once they enter a facility.

The Red Cross will be launching a public education campaign in the summer of 1988 relating to child safety as a part of its increased involvement in the area of pre-school aquatics.

REDCLIFF PARKS AND RECREATION DEPARTMENT

The following are a list of actions and policy changes adopted by the Town of Redcliff that will assist in the prevention of similar deaths:

1. The lifeguard assigned to the wading pool will be responsible for monitoring children leaving the pool and will request assistance from additional staff when necessary to ensure that children leave the facility safely.
2. Staff have been instructed to pay particular attention to younger children admitting themselves into the facility. The minimum age limit for children permitted to enter

the facility unaccompanied by an adult has been increased from four to six years of age.

3. It has been re-emphasized to lifeguards that they must be more aware and cautious of the people around them, particularly to those children who are weaker swimmers.
4. Inservice training for all staff has been increased from monthly intervals to one session every week.
5. The existing policy of the Town of Redcliff regarding hiring of lifeguards is that aquatic qualifications shall be given prime hiring concern. The pool has always been staffed at least to the Standard of Practise for Swimming Pools published by Alberta Recreation and Parks, however, every effort will be made to encourage existing and potential employees to work towards receiving their N.L.S. Awards.
6. A 1.2 meter high chain link fence has been erected between the wading pool and the main swimming pool to assist in keeping the younger non-swimmers away from deep water.
7. The concern over irregular patches in the pool has been eliminated to this point. The former coating has been completely removed, and a new more common swimming pool paint has been applied to the pool.

ALBERTA RECREATION AND PARKS

1. The recommendations are consistent with the Standard of Practice for Swimming Pools published by this department.
2. We would specifically stress that lifeguarding is a serious business which requires the complete attention of swimming pool staff when they are on deck supervision. Further, we would encourage the segregation of non-swimmers from deep water. Finally, we support and encourage the concept of frequent and regular inservice training for swimming pool staff.

Case History 9

Natural. The decedent underwent an abdominal hysterectomy at the Stettler General Hospital. She was transferred post-operatively to the Red Deer Regional Hospital where she died.

Recommendations:

When the doctor is dealing with a patient with a significant risk factor, major surgery should only be done in an institution where there are several experts available to assist where there may be problems. This assistance is not usually available in rural hospitals.

Replies:

COLLEGE OF PHYSICIANS AND SURGEONS

This matter will be drawn to the attention of the profession.

ALBERTA HOSPITAL ASSOCIATION

The recommendation for the prevention of similar deaths centres on the medical judgement and management of a patient within the hospital privileges granted to the physician involved. Further comment in respect to this would best be obtained from the College of Physicians and Surgeons.

We certainly are of the opinion that the recommendation is a good one and in most instances is in fact practised, in keeping with providing high standards of cure in hospitals.

ALBERTA HOSPITALS AND MEDICAL CARE

This matter is more appropriately dealt with by the Alberta College of Physicians and Surgeons; however, the matter will be discussed with the board and administration of the Stettler General Hospital.

STETTLER HOSPITAL COMPLEX

The Stettler Hospital Complex policy and procedures are based on the College of Physicians and Surgeons guidelines. The board has been advised of the findings.

Case History 10

Unclassified. The decedent, an inmate of the Fort Saskatchewan Correctional Institution, was a known drug abuser. When his condition deteriorated to such an extent that the corrections staff alerted the medical staff, he was immediately transferred to the Fort Saskatchewan General Hospital, followed by transfer to the Royal Alexandra Hospital where he died. Cause of death was Hepatitis 'B' infection resulting from drug abuse involving communal use of a needle and syringe.

Recommendations:

1. The Correctional Institution should initiate a firm policy to ensure that inmates who are too ill to be in their cells, but upon first examination not ill enough to be sent to hospital in the city, should be put into the infirmary where follow-up observation can take place.
2. In order to minimize the flow of drugs into the institution, I make the following recommendations:
   a) Institutional staff should submit to random body checks, by search, and the additional requirement to provide bodily samples of blood and/or urine;

b) Inmates who return to the institution after being granted temporary absences should:

(i) if he or she is not classified as a drug abuser, be subjected to a random requirement to provide bodily samples of blood and/or urine;

(ii) if he is classified as a drug user, he or she should be both strip-searched and required to provide bodily samples of blood and/or urine;

c) Inmates or work parties outside the secure areas, whether on or off the institution grounds, should be subjected to the same routine as set out above in paragraph b);

d) The grounds and its perimeters should be the subject of more frequent searches by the staff, accompanied by dogs trained to discover narcotics;

e) Deliveries should be frequently, but randomly, examined before unloaded;

f) Consideration should be given to more open visits, but their numbers should be restricted. These visitations should be divided into inmate classifications, thus avoiding a mixture of drug users and abusers with those inmates who do not use or abuse drugs. The reduced numbers will be more easily scrutinized and controlled by the correctional staff. In exchange for the visitation privilege, some stricter form of visitor search should be considered and initiated.

Replies:

FORT SASKATCHEWAN CORRECTIONAL CENTRE

As director of the Fort Saskatchewan Correctional Centre, I am not authorized to speak for the department in this matter. The assistant deputy minister will be formally addressing these recommendations and will authorize any departmental policy adjustments. This centre will abide by these policy and procedural amendments.

ALBERTA SOLICITOR GENERAL

1. The Correctional Services Division has re-emphasized the standard practice in the instance where inmates, who are assessed to be too ill to be in their cells but not sufficiently ill to be transferred to a community hospital, will be immediately placed into an infirmary where such facilities exist.

2. a) The recommendation which would subject correctional personnel to random body checks, searches and the additional requirement to provide samples of blood and/or urine is clearly problematic. Notwithstanding that, should a case present itself where a staff member is suspected of introducing contraband articles into a correctional centre, the person under existing policy can be detained for search. Should the officer be found in possession of drugs or other contraband, the appropriate law enforcement agency is contacted, and criminal charges are laid.

b) In respect to the recommendation to strip-search and take blood and/or urine samples from inmates returning to the centres from temporary absence passes, please be advised that strip-searches of the categories of inmates outlined have been increased.

In addition, the Correctional Services Division has undertaken research into acquiring the most suitable/reliable urinalysis machines for this purpose. The intent is to place these testing devices in both the larger remand and sentenced facilities. (The Correctional Services Division has now purchased and is using electronic drug testing equipment.)

c) Inmates involved in work parties outside secure areas of the centre will be subjected to the same routine, i.e., strip-search and urinalysis testing for drugs.

d) More frequent searches of correctional centre grounds and perimeters will be undertaken by correctional staff. The added recommendation to use dogs is a limited resource; however, the RCMP will be accessed on a more frequent basis in larger correctional facilities.

e) While deliveries to correctional facilities are subject to search at the present time, the recommendation has been noted, and surveillance of this area will be increased by correctional centres.

f) The number of open visits permitted in larger remand and correctional centres in the province has been significantly reduced by almost 50 per cent. Care is taken to avoid mixing drug users and abusers with those inmates who do not use drugs. All inmates identified as drug abusers or drug users are automatically strip-searched after visiting.

In addition, any inmate found to be in possession of drugs of any description, aside from being criminally charged, automatically forfeits visiting privileges for a three-month period.

Case History 11

Undetermined. The deceased suffered a convulsion following an alleged fall, and she died before help could be summoned. There was evidence of previous physical abuse.

Recommendations:

Efforts should be made to impress on the band social worker involved in this case, and the public in general, of the serious nature of the obligation imposed by Section 3 of the Child Welfare Act.

Replies:

ALBERTA MUNICIPAL AFFAIRS

This matter is not within the mandate of the department; however, staff of the Native Services Unit will impress upon all those involved with the care and protection of native children of their duties and responsibilities pursuant to the Child Welfare Act.

ALBERTA SOCIAL SERVICES

While this child was not under a guardianship order or agreement at the time of her death, the death of any child must cause us concern, particularly given the suggestion that the child might have been in need of protective services under the provisions of the Child Welfare Act of Alberta.

The observations and recommendations are duly noted and, to the extent appropriate, will impact upon the efforts of the Children's Guardian.

INDIAN AND INUIT AFFAIRS CANADA

Our department currently funds the salary and travel component for two child welfare workers at the Samson Band. Their role is clearly to provide only child welfare support services in close liaison with Alberta Social Services. The provision of these services does not require a delegation of authority from the provincial Minister of Social Services. We totally support the recommendation made. In view of the fact Alberta Social Services has the legislated mandate for the provision of statutory services, we would encourage a review of respective roles between Alberta Social Services and the Samson child welfare workers. We would suggest that such a review be initiated by Alberta Social Services and would include the Samson Chief and Council.

In a review of the Samson Child Welfare Program, conducted by our department in 1987, a need for additional training as well as clearly defined goals and objectives for the child welfare staff were identified as recommendations to the Chief and Council.

METIS ASSOCIATION OF ALBERTA

No reply to date.

Case History 12

Accidental. The deceased succumbed to hypothermia when she was forced to walk home late at night. She could have survived for only a few minutes dressed as she was, and she had been drinking heavily.

Recommendations:

Because of the apparent abuse of alcohol by teens and preteens on this reserve, an intensive educational campaign should be undertaken to educate, advise and counsel young children about the dangers of use and abuse of alcohol.

Replies:

ALBERTA SOCIAL SERVICES

The Band's Family and Community Support Services established a Drop-In Centre in March 1986, and negotiations with the Department of the Solicitor General and Native Counselling Services of Alberta resulted in the employment of two youth development workers, commencing in June 1987. As well, the Alberta Alcohol and Drug Abuse Commission provides support to the community, in the form of workshops, on request.

The Northwest Region Office of this department has contracted with the Dene Tha Band to provide funding from July 31, 1987 until June 30, 1988, for the employment of a child welfare social worker who, reporting to the Band Manager, will research previous community support patterns and informal helping networks traditionally received or presented on Dene Tha and other native reserves. It is our hope that the outcome of this research will contribute to the alleviation of the substance abuse problem, not only in the Assumption area but also across the province.

INDIAN AND NORTHERN AFFAIRS CANADA

Funds have been made available to the Dene Tha Band through the National Native Alcohol and Drug Abuse Program in the amount of $121,000.00.

These funds are to be utilized primarily for the education and prevention of alcohol and drug abuse for the members of the Dene Tha Band through their community-based programs.

Federal and provincial agencies are working co-operatively to support band development of social programs which meet community needs. This should help to build a strong sense of community and social responsibility.

ALBERTA MUNICIPAL AFFAIRS

This department can not directly contribute to resolving such matters. Staff of the Native Services Unit within Municipal Affairs are very conscious of the need to assist, in whatever area necessary, to attempt to reduce or eliminate such occurrences.

DENE THA BAND

No reply to date.

For more information or additional copies of this report, contact:

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